HOME VISIT

Hospice Referral Form (Penang)

Tick the chosen provider, and send the completed form to the chosen provider.
(Service provision varies among providers; Referrers should check with respective providers if unfamiliar)

☐ **Penang Hospice Society**
(covers the state of Penang)
250-A, Jalan Air Itam, 10460 Pulau Pinang.
Tel (general inquiries): 04-2284140/04-2294140
HP for referrals: 016-2244140 Email: info@penanghospice.org.my

☐ **Palliative Unit, Pusat Perubatan USM Bertam**
(covers Penang, southern Kedah)
Institut Perubatan dan Pergigian Termaju, Universiti Sains Malaysia, 13200 Kepala Batas, Pulau Pinang.
Tel : 04-5622201/2203 HP: 012-347 6773 Email: paliatifippt@usm.my

☐ **Charis Hospice**
(covers Penang Island only)
26 & 28, Lintang Paya Terubong 3, 11060 Ayer Itam
Tel : 04-827 9668, HP: 011-1246 6757
Email : charishospice@gmail.com

☐ **Tzu Chi Foundation**
(Spiritual and psychological support; covers the state of Penang)
316, Jalan McCalister, 10450 Pulau Pinang
Tel: 04-2281013. Email: wooigeap@hotmail.com

Patient data and contact details

Name:_____ IC:_____

Patient contact number:_____ Age: _____ Marital status:_____ Gender: M / F

Person to contact:_____ Relationship to patient:_____

Person to contact:_____ Relationship to patient:_____

Address where the patient is going to stay: _____

_____

Address and contact details should be checked with the person before referral

Clinical information

Diagnosis, problems (symptoms, psycho-social-spiritual):_____

_____

_____

_____

_____

_____

Reason for referral:_____

Comorbidities: _____

_____

Latest lab (**please attach imaging with referral form**):_____

_____

_____

Medications:_____

_____

What has been discussed? : _____

_____

_____

_____

_____

_____

_____

Has the following been discussed	Patient	Family
Diagnosis	☐	☐
Severity	☐	☐
Prognosis	☐	☐
Disease treatment options	☐	☐
Advance care plan/preparations	☐	☐

Patient currently at Hospital Ward _____ / Nursing home_____ / Clinic / Home.
Advise patient/family to call hospice on arrival at home.

Referrer source information

Name, title:_____ Follow-up date (if applicable):_____

Unit/Department/Center:_____ Contact details:_____

Signature:_____ Date:_____